Attachment 1

Date: 9/1/87 FORM APPROVED OME NO 0938 0008

MABB-087-004-0

HEALTH INSURANCE CLAIM FORM

## Free Standing Ambulatory Surgical Center Services

## (CHECK APPLICABLE PROGRAM BLOCK BELOW)

MEDICARE (MEDICARE NO.)		DICAID EDICAID NO.I		MPUS INSOR'S ESNI	CHAMPVA (VA FILE NO.)		FECA BLACK LUI	wa [		THER	
1 PATIENT S NAME (LAST	NAME SIRS			INSURED (SUB				NA BAG EIG		AE MIDDLE INITIAL	
Recipient	In		,	MM   DD	YY		ame	NAME, FI	131 NAN	WE MIDDLE INTITAC	
4 PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)				5 PATIENT'S SEX	6 INSUR	8 INSURED'S LD NO IFOR PROGRAM CHECKED ABOVE INCLUDE ALL LETTERS!					
609 Willow				MALE X	FEMAL	• 1	234567890	)			
Anytown WI	53725	•		7 PATIENT'S RELATIONSHIP TO	INSURED	8 INSURED	S GROUP NO IOR GRO	UP NAME OR F	ECA CLAIN	A NO	
: ELEPHONE NO				SELF SPOUSE	THER	INSURED IS EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN					
9 OTHER HEALTH INSURANCE CO	VERAGE IENTER N D POLICY GR MED	IAME OF POLICYHOLDER AND DICAL ASSISTANCE NUMBERI		10. WAS CONDITION RELATED	то	11 INSURED	S ADDRESS (STREET (	LITY STATE Z	P CODE		
OI - P				A PATIENT'S EMPLOYMENT YES		M - 6					
					1	TELEPHONE NO.					
				B. ACCIDENT AUTO		STATUS OCTAMPUS SPONSOR'S  STATUS OCTAMPUS SPONSOR'S  STATUS OCTAMPUS SPONSOR'S  SPANCH OF SERVICE  RETIRED					
12 PATIENT'S OR AUTHORIZED PE I AUTHORIZE THE RELEASE OF OF GOVERNMENT BENEFITS EI	ANY MEDICAL IN	FORMATION NECESSARY TO F	MOCESS THIS	CLAIM I ALSO REQUEST PAYME RENT BELOW	13 ( AUTHO PHYSICI	13 I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW					
SIGNED / / / / /	/ / /	//////	/ /	/ / / / OATE /	/ / / / ,		HED OR ANTHOMIZED	PERSONI /	/ /	1.///	
PHYSICIAN OR SUPPLIER INFORMA  14 DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (ILMP)  15 DATE FIRST CONSULTED YOU FOR THIS CONDITION							16 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY GIVE DATES CHECK HERE				
						1/					
17 DATE MATIENT ABLE TO 18. DATES OF TOTAL DISABILITY RETURN TO WORK / FROM / THROUGH / THROUGH / THROUGH						/ FROM /					
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (ag. PUBLIC HEALTH AGENCY)							20 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES				
21 NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)							ADMITTED DISCHARGED  22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE?				
23 A DIAGNOSIS OR NATURE OF ILLNESS OR INJURY RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1.2							YES NO CHARGES				
1 216.5	OF ILLNESS OR	INJURY RELATE DIAGNOSI	S TO PROCED	OURE IN COLUMN D BY REFER	ENCE NUMBERS 1 2	3	В				
2					EPSOT YES X NO						
3						•	PRIOR AUTHORIZATION N				
24 A DATE OF SERVICE	C. FULLY DESCRIBE PRO	EDICAL SERVICES OR SUPPLI	] 。	P H LEAVE BLANK							
FROM TO	SERVICE	PROCEDURE CODE	(EXPLA	IN UNUSUAL SERVICES OR CI	RCUMSTANCES	DIAGNOSIS	CHARGES	UNITS	TOS.		
06/10/88	В	11401	EXC	ISION BENIGN	0.6 CM		xx xx	1.0	F		
							+ +				
								ļ			
						<u> </u>					
							-			Design	
										Patient Spenddown	
25. SIGNATURE OF PHYSICIAN CREDENTIALS) (I CERTIFY	THAT THE STATE	EMENTS ON THE REVERSE /	APPLY TO	26. ACCEPT ASSIGNMENT CLAIMS ONLY) (SEE BA	(GOVERNMENT	27. TOTAL	1	28. AMC		29 BALANCE DUE	
THIS BILL AND ARE MADE A PART THEREOF)											
		/ <u>/ / Ng /</u>	AND T	ELEPHONE NO.		_,m.c.					
			30. YOUR SOCIAL SECURITY NO.  I.M. Billing								
DATE MM/DD/YY I.M. PROVIDER				22 VOLUE SUM OVER 10	1	l W Williams					
1234JED				33. YOUR EMPLOYER + 0. N	<u>/                                    </u>	/ / 87	87654321				
PLACE OF SERVICE AND TYPE REMARKS:	E OF SERVICE (T	O.S.) CODES ON THE BACK		APPROVED BY			n HCFA-1500 n CHAMPUS-		-84) f	Form RRB-1500	